RULES
OF
THE TENNESSEE DEPARTMENT OF MENTAL HEALTH
AND DEVELOPMENTAL DISABILITIES

CHAPTER 0940-5-44
MINIMUM PROGRAM REQUIREMENTS FOR ALCOHOL AND DRUG ABUSE RESIDENTIAL DETOXIFICATION TREATMENT FACILITIES

TABLE OF CONTENTS

0940-5-44-.01 Definitions
0940-5-44-.02 Licensing Procedures
0940-5-44-.03 Disciplinary Procedures
0940-5-44-.04 Administration
0940-5-44-.05 Admissions, Discharges, and Transfers
0940-5-44-.06 Basic Services
0940-5-44-.07 Building Standards
0940-5-44-.08 Life Safety
0940-5-44-.09 Infectious and Hazardous Waste
0940-5-44-.10 Records and Reports
0940-5-44-.11 Client Rights
0940-5-44-.12 Policies and Procedures for Health Care Decision-Making
0940-5-44-.13 Disaster Preparedness
0940-5-44-.14 Appendix I

0940-5-44-.01 DEFINITIONS.

(1) Abuse. The infliction of physical pain, injury, or mental anguish on a client by a caretaker. Abuse includes "exploitation" as defined by these rules.

(2) A.D.A. Americans with Disabilities Act of 1990, 42 U.S.C. §12101 et seq.

(3) Adult. An individual who has capacity and is at least 18 years of age.

(4) Advance Directive. An individual instruction or a written statement relating to the subsequent provision of health care for the individual, including, but not limited to, a living will or a durable power of attorney for health care.

(5) Aftercare Plan. A plan which specifies, as appropriate, referral for further counseling and/or treatment services at another level of care, the type of contact, planned frequency of contact and the staff responsible for referrals. The focus of the aftercare phase is to ensure ongoing achievement of goals.

(6) Agent. An individual designated in an advance directive for health care to make a health care decision for the individual granting the power.

(7) Alcohol and/or Other Drug Abuse. A condition characterized by the continuous or episodic use of alcohol and/or other drugs resulting in social impairment, vocational impairment, psychological dependence or pathological patterns of use as defined in currently accepted diagnostic nomenclature.

(8) Alcohol and/or Other Drug Dependency. Alcohol and/or other drug abuse which results in the development of tolerance or manifestation of alcohol and/or other drug abstinence syndrome upon cessation of use as defined in currently accepted diagnostic nomenclature.

(9) Ambulatory Client. A client who is physically and mentally capable under emergency conditions of finding a way to safety without physical assistance from another person. An ambulatory resident may use a cane, wheelchair or other supportive device and may require verbal prompting.

(10) ASHRAE. American Society of Heating, Refrigeration and Air Conditioning Engineers.

(Rule 0940-5-44-.01, continued)

(11) Assessment. A documented evaluation of a client for the purpose of determining treatment and/or rehabilitation needs. An assessment may, but does not necessarily, include examinations and tests determined to be necessary by the treatment staff based on the presenting problems and symptoms of the individual client.

(12) Board. The Board for Licensing Health Care Facilities.

(13) Capable of Self-Preservation. A person is capable of responding to an approved emergency signal, including prompting by voice, by following a pre-taught evacuation procedure within a reasonable time limitation whether or not the person is fully aware of the reasons for the action. A person is capable of self-preservation if the person is able to transfer unassisted from the bed or another fixed position to an individualized means of mobility, which is continuously available, and able to demonstrate the ability to transverse a pre-defined means of egress from the facility within thirteen (13) minutes. Persons who have imposed upon them security measures beyond their control, which prevent their egress from the facility within a reasonable time limitation, are not capable of self-preservation.

(14) Capacity. An individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision. These regulations do not affect the right of a client to make health care decisions while having the capacity to do so. A client shall be presumed to have capacity to make a health care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate. Any person who challenges the capacity of a client shall have the burden of proving lack of capacity.

(15) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to restore or support cardiopulmonary functions in a patient, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilations or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a patient where cardiac or respiratory arrest has occurred or is believed to be imminent.

(16) Case Management. A method or process for ensuring that individuals are provided needed services in a coordinated, effective and efficient manner.

(17) Chief Executive Officer or Director. The person appointed, designated, or hired by the governing body to be responsible for the day-to-day operation of the facility or facilities operated by the licensee.

(18) Client. The individual who is the direct recipient of the services provided by a residential detoxification treatment facility subject to the licensure jurisdiction of the Tennessee Department of Health.

(19) Client Record. A written and authenticated compilation of those events and processes that describe and document the assessment and treatment of the client, to include but not be limited to medical histories, lab and x-ray reports, discharge summaries, treatment, plan and progress notes.

(20) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.

(21) Competent. A client who has capacity.

(Rule 0940-5-44-.01, continued)

(22) Continuum of Care. A structure of interlinked treatment modalities and services designed so that an individual's changing needs will be met as that individual moves through the treatment and recovery process.

(23) Corrective Action Plan/Report. A report filed with the department by the facility after reporting an unusual event. The report must consist of the following:

(a) the action(s) implemented to prevent the reoccurrence of the unusual event,

(b) the time frames for the action(s) to be implemented,

(c) the person(s) designated to implement and monitor the action(s), and

(d) the strategies for the measurements of effectiveness to be established.

(24) Department. The Tennessee Department of Health.

(25) Designated Physician. A physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes such responsibility.

(26) Detoxification. A process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.

(27) Do Not Resuscitate (DNR) Order. An order entered by the client treating physician in the client's medical record which states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The order may contain limiting language to allow only certain types of cardiopulmonary resuscitation to the exclusion of other types of cardiopulmonary resuscitation.

(28) Emancipated Minor. Any minor who is or has been married or has by court order or otherwise been freed from the care, custody and control of the minor's parents.

(29) Emergency Responder. A paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function under law or rendering emergency care at the scene of an emergency.

(30) Exploitation. The improper use by a caretaker of funds which have been paid by a governmental agency to a client or to the caretaker for the use or care of the client; the "borrowing" or improper solicitation, use or conversion of any monies or property paid by a person or entity to a client or to the caretaker for the use or care of the client; engaging in sexual contact or sexual penetration with a client by the caretaker; coercion, conspiring with or aiding a client to engage in any criminal activity by the caretaker.

(31) Facility. An institution, treatment resource, group residence, boarding home, sheltered workshop, activity center, rehabilitation center, hospital, community mental health center, DUI school, counseling center, clinic, halfway house, or other entity by these or other names, providing alcohol and drug abuse services.

(32) Governing Body. The person or persons with primary legal authority and responsibility for the overall operation of the facility and to whom a director/chief executive officer is responsible. Depending upon the organizational structure, this body may be an owner or

(Rule 0940-5-44-.01, continued)

owners, a board of directors or other governing members of the licensee, or state, city or county officials appointed by the licensee.

(33) Grievance Procedure. A procedure for responding to an expression of a cause of distress believed by a client, or by another acting on behalf of a client, to constitute a reason for complaint.

(34) Guardian. A judicially appointed guardian or conservator having authority to make a health care decision for an individual.

(35) Health Care. Any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5).

(36) Health Care Decision. Consent, refusal of consent or withdrawal of consent to health care.

(37) Health Care Decision-maker. In the case of a client who lacks capacity, the client's health care decision-maker is one of the following: the client's health care agent as specified in an advance directive, the client's court-appointed guardian or conservator with health care decision-making authority, the client's surrogate as determined pursuant to Rule 0940-5-44-.12 or T.C.A. §33-3-220, the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.

(38) Health Care Institution. A health care institution as defined in T.C.A. § 68-11-1602.

(39) Health Care Provider. A person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business of practice or a profession.

(40) Incompetent. A client who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.

(41) Individual instruction. An individual's direction concerning a health care decision for the individual.

(42) Legal Conservator. The person legally appointed by a court of competent jurisdiction to have full or limited control of a client's person and/or property.

(43) Licensed Clinical Psychologist. A psychologist licensed to practice psychology in Tennessee and designated as a health service provider as determined by the Board of Examiners in Psychology pursuant to T.C.A. §§ 63-11-208 and 63-11-223.

(44) Licensed Practical Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(45) Licensee. The person or entity to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.

(46) Life Threatening Or Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.

(47) Medically Inappropriate Treatment. Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the client or other medical or surgical treatments to achieve the expressed goals of the informed client. In the case of the incompetent client, the client's representative expresses the goals of the client.

(Rule 0940-5-44-.01, continued)

(48) Neglect. The deprivation of services, including adequate and nutritious food and drink, by a caretaker, which are necessary to maintain the health and welfare of the client. Neglect includes "exploitation" as defined by these rules.

(49) On Duty/On Site. A staff person who is on the facility's premises and has the obligation to carry out any job responsibilities designated in his/her job description.

(50) On Site. A staff person who is on the facility's premises but is only required to be on duty during an emergency.

(51) Patient Abuse. Patient neglect, intentional infliction of pain, injury, or mental anguish. Patient abuse includes the deprivation of services by a caretaker which are necessary to maintain the health and welfare of a patient or resident; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of such living will shall not be deemed "patient abuse" for purposes of these rules.

(52) Person. An individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(53) Personally Informing. A communication by any effective means from the client directly to a health care provider.

(54) Physician. An individual authorized to practice medicine or osteopathy under Tennessee Code Annotated, Title 63, Chapters 6 or 9.

(55) Power of Attorney for Health Care. The designation of an agent to make health care decisions for the individual granting the power under T.C.A. Title 34, Chapter 6, Part 2.

(56) Qualified Alcohol and Other Drug Abuse Personnel - Persons who meet the criteria described in items (a), (b) and (c) as follows:

(a) Currently meet one (1) of the following conditions:

1. Licensed or certified by the State of Tennessee as a physician, registered nurse, practical nurse, psychologist, psychological examiner, social worker, alcohol and other drugs of abuse counselor, teacher, professional counselor, or marital and family therapist, or if there is no applicable licensure or certification by the state, has a bachelor's degree or above in a behavioral science or human development related area; or

2. Actively engaged in a recognized course of study or other formal process for meeting criteria of part (1) of item (a) above, and directly supervised by a staff person who meets criteria in part (1) of item (a) above, who is trained and qualified as described in items (b) and (c) below, and who has a minimum of two (2) years experience in his/her area of practice; and

(b) Are qualified by education and/or experience for the specific duties of their position; and

(c) Are trained in alcohol or other drug specific information or skills. Examples of types of training include, but are not limited to, alcohol or other drug specific inservices,

(Rule 0940-5-44-.01, continued)

workshops, substance abuse schools, academic coursework and internships, field placement, or residencies.

(57) Qualified Emergency Medical Service Personnel. Includes, but shall not be limited to, emergency medical technicians, paramedics, or other emergency services personnel, providers, or entities acting within the usual course of their professions, and other emergency responders.

(58) Reasonably Available. Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the client's health care needs. Such availability shall include, but not be limited to, availability by telephone.

(59) Rehabilitation Services. Services which restore the client, family members, or significant other to an optimum state of health through the use of medical psychological and social means including peer support.

(60) Registered Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(61) Residential Detoxification Treatment Facility. A 24-hour a day, 7 day a week intensive residential facility providing medically supervised care and treatment to clients experiencing severe withdrawal and whose medical needs are paramount.

(62) Restraint. Any physical or mechanical device or chemical substance used to restrict the movement of an individual or the movement or normal function of a portion of an individual's body.

(63) Restrictive Procedure. A treatment procedure that limits the rights of the individual for the purpose of modifying problem behavior, including but not limited to, time out and restraint.

(64) Resuscitative Services. See Cardiopulmonary Resuscitation.

(65) Significant Others. Those individuals who are, or have been, significantly involved in the life of the client.

(66) Spiritual Counselor. A person who has met the requirements of a religious organization to serve the constituency of that organization.

(67) State. A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(68) Supervising Health Care Provider. The designated physician or, if there is no designated physician or the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(69) Surrogate. An individual, other than a client's agent or guardian, authorized to make a health care decision for the client.

(70) Time Out. A behavior management procedure in which, contingent upon the demonstration of undesired behavior, the opportunity for positive reinforcement is withheld.

(71) Treating Physician. A duly licensed physician selected by or assigned to the client and who has the primary responsibility for the treatment and care of the client. Where more than one physician shares such responsibility, any such physician may be deemed to be the "treating physician".

(Rule 0940-5-44-.01, continued)

(72) Treating Health Care Provider. A health care provider who at the time is directly or indirectly involved in providing health care to the client.

(73) Treatment Plan. A document used by alcohol and drug agencies that specifies a client's projected programmatic activities for a defined time period.

(74) Universal Do Not Resuscitate Order. A written order that applies regardless of the treatment setting and that is signed by the patient's physician which states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The Physician Order for Scope of Treatment (POST) form promulgated by the Board for Licensing Health Care Facilities as a mandatory form shall serve as the Universal DNR according to these rules.

(75) Unusual Event. The abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient that is not related to a natural course of the patient's illness or underlying condition.

(76) Unusual Event Report. A report form designated by the department to be used for reporting an unusual event.

(77) Volunteer. A person who is not paid by the licensee and whose varied skills are used by the licensee to support and supplement the efforts of the paid facility staff.

Authority: *T.C.A. §§4-5-202, 4-5-204, 34-11-101, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-208, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, and 68-11-1802 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendments filed January 4, 2006; effective March 20, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

0940-5-44-.02 LICENSING PROCEDURES.

(1) No person, partnership, association, corporation, any state, county, or local governmental unit, or any division, department, board or agency thereof, shall establish, conduct, operate or maintain in the State of Tennessee any Residential Detoxification Treatment Facility as defined, without having a license. A license shall be issued only to the applicant named and only for the premises listed in the application for licensure. Licenses are not transferable or assignable and shall expire annually on June 30th. The license shall be conspicuously posted in the Residential Detoxification Treatment Facility.

(2) In order to make application for a license:

(a) The applicant shall submit an application on a form provided by the department;

(b) Each initial and renewal application for licensure shall be submitted with the appropriate fee or fees. All fees submitted are nonrefundable. The fee rate is based on the number of distinct facility categories to be operated at each residential and non-residential site. Any applicant who files an application during the fiscal year must pay the full license fee. A fee must be submitted for each facility at each site for which licensure is being sought under the following schedule:

1.	Residential	Fees Per Site:
	2 - 3 Beds	$ 150.00

(Rule 0940-5-44-.02, continued)

4 - 10 Beds	210.00
11-15 Beds	300.00
16-50 Beds	600.00
More than 50 Beds	900.00

2. Non-Residential Fees Per Site:

   One (1) Distinct Facility Category $ 600.00

3. An additional fee of $150.00 is required for each additional distinct facility category to be licensed in conjunction with the above. When additional beds are licensed, the difference between the fee already paid and the fee for the new bed capacity, if any, must be paid.

(c) The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the department. Clients shall not be admitted to the Residential Detoxification Treatment Facility until a license has been issued. Applicants shall not hold themselves out to the public as being a Residential Detoxification Treatment Facility until the license has been issued. A license shall not be issued until the facility is in substantial compliance with these rules and regulations;

(d) The applicant shall prove the ability to meet the financial needs of the facility;

(e) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an individual has been denied a license or has had a license disciplined or has attempted to avoid inspection and review process.

(3) Every facility owner or operator shall designate a distinctive name for the facility which shall be on the application for a license. The name of a facility shall not be changed without first notifying the department in writing. The change will be made when renewal of the license is due.

(4) A separate license shall be required for each facility when more than one facility is operated under the same management or ownership.

(5) A proposed change of ownership, including a change in a controlling interest, shall be reported to the department a minimum of thirty (30) days prior to the change. Upon a change of ownership the existing license is terminated and the new owner is required to submit an application with the licensing fee, be inspected and meet the applicable standards and regulations as is required for initial licensing.

(a) For the purpose of licensing, the licensee of an Residential Detoxification Treatment Facility has the ultimate responsibility for the operation of the facility, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of Residential Detoxification Treatment Facility's operation is transferred.

(b) A change of ownership occurs whenever there is a change in the legal structure by which the Residential Detoxification Treatment Facility is owned and operated.

(c) Transactions constituting a change of ownership include, but are not limited to, the following:

(Rule 0940-5-44-.02, continued)

1. Transfer of the facility's legal title;

2. Lease of the facility's operations;

3. Dissolution of any partnership that owns, or owns a controlling interest in, the facility;

4. One partnership is replaced by another through the removal, addition or substitution of a partner;

5. Removal of the general partner or general partners, if the facility is owned by a limited partnership;

6. Merger of a facility owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are canceled;

7. The consolidation of a corporate facility owner with one or more corporations; or,

8. Transfers between levels of government.

(d) Transactions which do not constitute a change of ownership include, but are not limited to, the following:

1. Changes in the membership of a corporate board of directors or board of trustees;

2. Two (2) or more corporations merge and the originally-licensed corporation survives;

3. Changes in the membership of a non-profit corporation;

4. Transfers between departments of the same level of government; or,

5. Corporate stock transfers or sales, even when a controlling interest.

(e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the facility. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.

(f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the facility's entire real and personal property and if the identity of the lessee, who shall continue the operation, retains the exact same legal form as the former owner.

(6) To be eligible for a license or renewal of a license, each Residential Detoxification Treatment Facility shall be periodically inspected for compliance with these regulations. If deficiencies are identified, an acceptable plan of correction shall be established and submitted to the department.

(7) The department shall be notified at least 30 days in advance of a facility's closing.

Authority: *T.C.A. §§4-5-202 through 4-5-206, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-210, 68-11-213, and 68-11-216 and Executive Order 44 (February 23, 2007).* ***Administrative History:***

(Rule 0940-5-44-.02, continued)
Original rule filed April 27, 2000; effective July 11, 2000. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.

0940-5-44-.03 DISCIPLINARY PROCEDURES.

(1) The board may suspend or revoke a license for:

(a) Violation of federal or state statutes;

(b) Violation of the rules as set forth in this chapter;

(c) Permitting, aiding or abetting the commission of any illegal act in the Residential Detoxification Treatment Facility;

(d) Conduct or practice found by the board to be detrimental to the health, safety, or welfare of the clients of the Residential Detoxification Treatment Facility; or,

(e) Failure to renew the license.

(2) The board may consider all factors which it deems relevant, including but not limited to the following, when determining sanctions:

(a) The degree of sanctions necessary to ensure immediate and continued compliance;

(b) The character and degree of impact of the violation on the health, safety and welfare of the patients in the facility;

(c) The conduct of the facility in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and,

(d) Any prior violations by the facility of statutes, rules or orders of the board.

(3) When a Residential Detoxification Treatment Facility is found by the department to have committed a violation of this chapter, the department will issue to the facility a statement of deficiencies. Within ten (10) days of the receipt of the statement of deficiencies the facility shall return a plan of correction indicating the following:

(a) How the deficiency will be corrected;

(b) The date upon which each deficiency will be corrected;

(c) What measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and,

(d) How the corrective action will be monitored to ensure that the deficient practice does not recur.

(4) Either failure to submit a plan of correction in a timely manner or a finding by the department that the plan of correction is unacceptable shall subject the facility's license to possible disciplinary action.

(5) Any licensee or applicant for a license, aggrieved by a decision or action of the department or board, pursuant to this chapter, may request a hearing before the board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Administrative Procedures Act, T.C.A. §§ 4-5-101 et seq.

(Rule 0940-5-44-.03, continued)

(6) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

Authority: *T.C.A. §§4-5-202 through 4-5-206, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, 68-11-206 through 68-11-209, and 68-11-213 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Amendment filed March 1, 2007; effective May 15, 2007. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

0940-5-44-.04 ADMINISTRATION.

(1) The Governing Body shall ensure the following:

(a) The facility complies with all applicable federal, state, and local laws, ordinances, rules and regulations;

(b) The facility is administered and operated in accordance with written policies and procedures;

(c) The general direction over the facility and the establishment of policies governing the operation of the facility and the welfare of the individuals served; and

(d) That a responsible individual be designated for the operation of the facility in the absence of the licensee.

(2) A current written policies and procedures manual shall be maintained. The manual must include the following elements:

(a) An organizational chart or a statement which clearly shows or describes the lines of authority between the governing body, the chief executive officer, and the staff;

(b) A description of facility services provided by the licensee. The description shall include at a minimum the hours of operation and admission and discharge criteria;

(c) Exclusion criteria for persons not appropriate for admission;

(d) A schedule of fees, if any, currently charged to the client for all services provided by the licensee;

(e) The intake and assessment process;

(f) A description of the facility's aftercare service;

(g) A statement of client rights;

(h) Grievance procedures for the client, physician, relative, or significant other;

(i) A policy and procedures which ensure the confidentiality of client information and which include the following provisions:

1. The facility staff shall comply with applicable confidentiality laws and regulations;

(Rule 0940-5-44-.04, continued)

2. The client shall not be required to make public statements which acknowledge gratitude to the licensee or for the licensee's facility services;

3. The client shall not be required to perform in public gatherings; and

4. Identifiable photographs of the client shall not be used without the written and signed consent of the client or the client's guardian;

(j) A policy which prohibits clients from having any of the following responsibilities:

1. Responsibility for the care of other clients; and,

2. Responsibilities requiring access to confidential information;

(k) A policy and procedures to be followed in the reporting and investigation of suspected or alleged abuse or neglect of clients, or other critical incidents. The procedures shall include provisions for corrective action to be taken as a result of such reporting and investigation;

(l) Volunteers, if used by the facility, shall be in a supportive capacity and be under the supervision of appropriate designated staff members and understand confidentiality and privacy of the client;

(m) Procedures for admitting and assessing deaf and hard of hearing clients shall include, but not be limited to:

1. The provision of intake screening and counseling personnel who are knowledgeable in issues affecting evaluation, psychosocial development and impacts of deafness/hard of hearing on clients and families;

2. Mechanisms for providing sign language interpreters for all clients whose primary means of communication is through manual communication;

3. All facilities should have a telecommunication device for the deaf (TDD), but if not available, shall have a written arrangement for a relay system providing TDD type access (relay systems as described in the American Disabilities Act handbook published by U.S. Department of Justice and U.S. Equal Employment Opportunity Commission reference section 35.161); and

4. All facilities having TDD access shall indicate it in publications such as telephone books, brochures, letterheads, etc.;

(n) Client behavior management techniques, if used by the facility;

(o) Methods for managing disruptive behavior which respect the rights of their clients;

(p) Any restrictive procedure shall be used by the facility only after all less-restrictive alternatives for dealing with the problem have been systematically tried or considered and have been determined to be inappropriate or ineffective:

1. The restrictive procedure(s) shall be justifiable, and meet all requirements for use; and

2. Only qualified personnel may use restrictive procedures and shall be adequately trained in their use;

(q) An assurance and procedures to be followed to comply with “drug free workplace” which will minimally include:

1. Developing a policy explaining the rules about drugs in the workplace, including drug-testing procedures, if used by the facility;

2. Distributing the policy to employees (documentation required);

3. Providing periodic (at least once yearly) educational programs to employees regarding the policy and general substance abuse information;

4. Referring substance abusing employees to an Employee Assistance Program or local alcohol and drug treatment center; and,

5. Distributing written information such as pamphlets and posters regarding substance abuse to employees;

(r) The plans and procedures to be followed in the event of an emergency involving client care which will provide for emergency CPR and initial care at the facility, emergency transportation of clients, emergency medical care, and staff coverage in such events;

(s) A policy addressing its awareness of, and intent to comply with, the Americans with Disabilities Act of 1990.

(3) Financial Management.

(a) The licensee holding or receiving funds or property for the client as trustee or representative payee will adhere to all laws, state and federal, that govern his position and relation to the client.

(b) The licensee shall prohibit staff and proprietors from borrowing money from clients.

(c) The licensee shall ensure that all money held and disbursed in the client’s behalf is for the strict, personal benefit of the client.

(d) The licensee shall not mix its funds with those of the client.

(e) The licensee shall not take funds or property of the client for the facility's own use or gain.

(4) Personnel.

(a) A personnel record for each staff member of a facility shall include an application for employment and a record of any disciplinary action taken.

(b) Wage and salary information, time records, and authorization and record of leave, shall be maintained but may be kept in a separate location.

(c) A job description shall be maintained which includes the employment requirements and the job responsibilities for each facility staff position.

(d) A personnel record shall be maintained which verifies that each employee meets the respective employment requirements for the staff position held, including annual verification of basic skills and annual evaluation of personnel performance. This

(Rule 0940-5-44-.04, continued)

evaluation shall be in writing. There shall be documentation to verify that the employee has reviewed the evaluation and has had an opportunity to comment on it.

(e) Training and development activities which are appropriate in assisting the staff in meeting the needs of the clients being served shall be provided for each staff member including STD/HIV education. The provision of such activities shall be evidenced by documentation in the facility records.

(f) Training and development activities which are appropriate in assisting volunteers (if volunteers are used by the facility) in implementing their assigned duties shall be provided for each volunteer. The provision of such activities shall be evidenced by documentation in the facility's records.

(g) Direct-services staff members shall be competent persons aged eighteen (18) years of age or older.

(h) All new employees, including volunteers, who have routine contact with clients shall have a current tuberculosis test prior to employment.

(i) Employees shall have a tuberculin skin test annually and at the time of exposure to active TB and three months after exposure.

(j) Employee records shall include date and type of tuberculin skin test used and date of tuberculin skin test results, date and results of chest x-ray, and any drug treatment for tuberculosis.

(5) Staffing.

(a) Direct-treatment and/or rehabilitation services shall be provided by qualified alcohol and other drug abuse personnel, whose skills are evaluated annually.

(b) A physician shall be employed or retained by a written agreement to serve as medical consultant to the program.

(c) At least one (1) on-duty staff member shall be trained in CPR, first aid, and the Heimlich maneuver.

(d) The facility shall have a written weekly schedule of all program services and client activities for each day specifying, the types of services/activities and scheduled times.

(e) For life safety purposes, the facility shall maintain an on-duty/on-site staff-to-client ratio of at least one (1) to sixteen (16) at each building. This includes during sleeping hours.

(6) Community Information, Consultation, and Outreach Services.

(a) Community information, consultation and outreach services shall be designed to reach the agency's target population, to promote available services, and to give information on substance abuse services and other related issues to the general public, the target population, and the other agencies serving the target population. The services should include presentations to human services agencies, community organizations, and individuals (other than individuals in treatment and staff). Community presentations, films, and other visual displays and discussions in which factual information is disseminated should be made by staff members or trained volunteers.

(Rule 0940-5-44-.04, continued)

(b) Written documentation on all community information/outreach activities shall be maintained and shall include:

1. The organization/persons receiving the service;

2. Name of person(s) providing the service;

3. Number of persons attending;

4. Date the service was delivered; and,

5. Description of service.

(7) All health care facilities licensed pursuant to T.C.A. §§ 68-11-201, et seq. shall post the following in the main public entrance:

(a) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office;

(b) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation; and

(c) A statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in boldface type, for immediate assistance and posted on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height.

Postings of (a) and (b) shall be on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height.

Authority: *T.C.A. §§4-5-202 through 4-5-206, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-222, and 71-6-121 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Amendment filed April 30, 2003; effective July 14, 2003. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed July 18, 2007; effective October 1, 2007. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

0940-5-44-.05 ADMISSIONS, DISCHARGES AND TRANSFERS.

(1) The intake and assessment process shall include the following:

(a) The information to be obtained on all applicants or referrals for admission;

(b) The procedures for accepting referrals from outside agencies or organizations;

(c) The records to be kept on all applicants;

(d) Any prospective client data to be recorded during the intake process; and

(e) The procedures to be followed when an applicant or a referral is found eligible for admission.

(2) An aftercare plan shall be developed which specifies the type of contact, planned frequency of contact, and responsible staff, or documentation that the client was offered aftercare but

decided not to participate, or documentation that the client dropped out of treatment and is therefore not available for aftercare planning, or verification that the client is admitted for further alcohol and drug treatment services.

(3) Any residential facility licensed by the board of licensing health care facilities shall upon admission provide to each resident the division of adult protective services' statewide toll-free number: 888-277-8366.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 71-6-121 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Amendment filed April 20, 2006; effective July 4, 2006. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

0940-5-44-.06 BASIC SERVICES.

(1) Assessment.

(a) The facility shall complete an assessment and document the findings prior to development of the Treatment Plan. The assessment shall consist of the following information:

1. Assessment of current functioning according to presenting problem, including history of the presenting problem;

2. Basic medical history and information, including drug usage, a determination of the necessity of a medical evaluation and a copy, where applicable, of the results of the medical evaluation, as deemed necessary by the program physician. The medical evaluation will include documentation of a tuberculin skin test, the type of tuberculin skin test used, the results of the tuberculin skin test and, if applicable, the date and result of a chest x-ray and any drug treatment for tuberculosis;

3. A six (6) month history of prescribed and frequently used over-the-counter medications and other drugs including patterns specific usage for past 30 days; and,

4. The assessment information shall include employment/educational/ financial, emotional/psychological health, social/family/peer, physical health, legal and community living skills/housing information, and the impact of the client's substance abuse in each area.

(b) A Treatment Plan which meets the following requirements, shall be developed and documented for each client which:

1. Shall be developed within seven (7) days of admission;

2. Includes the client's name in the treatment plan;

3. Includes the date of development of the treatment plan;

4. Includes specified client problems in the treatment plan which are to be addressed within the particular service/program component;

5. Includes client goals which are related to specified problems in the treatment plan and which are to be addressed within the particular service/program component;

6. Includes interventions addressing goals in the treatment plan;

7. Includes the signatures of appropriate staff; and,

8. Includes documentation of client's participation in the treatment planning process.

(c) The facility shall review and, if indicated, revise the Treatment Plan at least every seven (7) days. The revision shall document any of the following which apply:

1. Change in goals and objectives based upon client's documented progress or identification of any new problems.

2. Change in primary counselor assignment.

3. Change in frequency and types of services provided.

4. A statement documenting review and explanation if no changes are made in the treatment plan.

(d) The facility shall provide services, as available, to clients to address their needs as indicated, in the assessment history, in the areas of employment/ educational/ financial, emotional/ psychological health, social/ family/ peer, physical health, legal and community living skills/ housing. Such services may be provided directly by the agency or indirectly by referral to other service providers. Referral agreements with frequently-used providers shall be documented. The provision of such services to individual clients shall be documented.

(2) Counseling services shall be made available to the individual, the individual's family and/or significant other. Counseling includes alcohol and drug, dietary, spiritual and any other counseling services identified in the plan of care of the individual and family and/or significant other provided while the individual is a client of the Residential Detoxification Treatment Facility. The client should receive at least six (6) hours of group and individual therapy each week as well as the client's attendance of substance abuse and other educational services.

(3) Physician Services.

(a) Policies and procedures concerning services provided by the facility shall be available for the admitting physicians.

(b) Clients shall be aided in receiving dental care as deemed necessary.

(c) Each facility shall retain, by written agreement, a physician to serve as a Medical Director.

(d) The Medical Director shall be responsible for the medical care in the facility. The Medical Director shall:

1. Ensure the delivery of emergency and medical care when the client's attending physician or his/her designated alternate is unavailable;

2. Make periodic visits to the facility to evaluate the existing conditions and make recommendations for improvements;

(Rule 0940-5-44-.06, continued)

3. Advise and provide consultation on matters regarding medical care, standards of care, surveillance and infection control.

(4) Nursing Services.

(a) Nursing services shall be provided in the facility and shall be supervised by a registered nurse.

(b) Nursing service shall delineate the responsibility for the operation of nursing services including the type of nursing personnel necessary to provide the services required.

(c) Statement of responsibilities shall be developed, maintained and periodically updated.

(d) There shall be a written job description shall be developed and maintained for each level of nursing personnel.

(e) Nursing service shall notify client's physician when necessary.

(f) Nursing service shall supervise the administration of medication.

1. The facility shall consider the client's ability and training when supervising the administration of medication.

2. The facility shall ensure that prescription medications are taken only by clients for whom they are prescribed and in accordance with the direction of a physician.

3. The facility shall ensure that medications are stored in a locked container which ensures proper conditions of security, sanitation and prevents accessibility by any unauthorized person.

4. The facility shall dispose of discontinued, outdated medications and containers with worn, illegible, or missing labels.

5. All medication errors, drug reactions, or suspected over-medications shall be reported to the practitioner who prescribed the drug.

6. Documentation of the current prescription of each medication taken by a client shall be maintained by the facility.

(5) Infection Control.

(a) The facility shall provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There shall be an active program for the prevention, control, and investigation of infections and communicable diseases.

(b) The administrator shall assure that an infection control program including members of the medical staff, nursing staff and administrative staff develop guidelines and techniques for the prevention, surveillance, control and reporting of facility infections. Duties of the program shall include the establishment of:

1. Written infection control policies;

2. Techniques and systems for identifying, reporting, investigating and controlling infections in the facility;

(Rule 0940-5-44-.06, continued)

3. Written procedures governing the use of aseptic techniques and procedures in the facility;

4. Written procedures concerning food handling, laundry practices, disposal of environmental and resident wastes, traffic control and visiting rules, sources of air pollution, and routine culturing of autoclaves and sterilizers;

5. A log of incidents related to infectious and communicable diseases;

6. Formal provisions to educate and orient all appropriate personnel in the practice of aseptic techniques such as handwashing, proper grooming, masking, dressing care techniques, disinfecting and sterilizing techniques, and the handling and storage of client care equipment and supplies; and,

7. Continuing education for all facility personnel on the cause, effect, transmission, prevention, and elimination of infections.

(c) The administrator shall ensure that the facility-wide performance improvement program and training programs address problems identified by the infection control program and shall be responsible for the implementation of successful corrective action plans in affected problem areas.

(d) The facility shall develop policies and procedures for testing a client blood for the presence of the hepatitis B virus and the HIV virus in the event that an employee of the facility, a student studying at the facility, or other health care providers rendering services at the facility is exposed to a client's blood or other body fluid. The testing shall be performed at no charge to the client, and the test results shall be confidential.

(e) The facility and its employees shall adopt and utilize standard or universal precautions of the Centers for Disease Control (CDC) for preventing transmission of infections, HIV, and communicable diseases.

(f) Guidelines for human subjects in research shall be developed, if the facility is involved or planning to be involved in such research, and shall include:

1. A tuberculin skin test within the first seven (7) days of admission or documentation that such a test was performed within the past thirty (30) days;

2. Infectious disease testing will be made on a voluntary basis for any client who requests it and be documented in appropriate records;

3. Assurance that a client's HIV, other STD, or tuberculosis status be kept confidential in accordance with "Confidentiality of Alcohol and Drug Abuse Patient Records". (42 CFR, Part 2);

4. Documentation on the establishment of linkages between the facility and the local health department to ensure clients receive appropriate medical care relative to their infection and/or exposure to TB, hepatitis B, and STD (including HIV); including but not limited to, the establishment of contact between the local health department and the facility to communicate appropriate information to assure that the client receives appropriate care;

5. Decreasing transmission of infections, HIV, and communicable diseases through environmental precautions and appropriate sanitation/ventilation measures;

(Rule 0940-5-44-.06, continued)

6. Informed consent of clients before screening and treatment; and,

7. Conducting case management activities to ensure that individuals receive HIV/AIDS, hepatitis B virus, other STD and tuberculosis services.

(6) Performance Improvement.

(a) The facility shall ensure that there is an effective, facility-wide performance improvement program to evaluate client care and performance of the organization.

(b) The performance improvement program shall be ongoing and have a written plan of implementation which assures that:

1. All organized services related to client care, including services furnished by a contractor, are evaluated;

2. Nosocomial infections and medication therapy are evaluated; and,

3. All services performed in the facility are evaluated as to the appropriateness of diagnosis and treatment.

(c) The facility shall have an ongoing plan, consistent with available community and facility resources, to provide or make available services that meet the needs of its clients.

(d) The facility shall develop and implement plans for improvement to address deficiencies identified by the performance improvement program and must document the outcome of the remedial action.

(e) Performance improvement program records are not disclosable, except when such disclosure is required to demonstrate compliance with this section.

(f) Good faith attempts by the Performance Improvement Program Committee to identify and correct deficiencies will not be used as a basis for sanctions.

(7) Recreational Activities. The facility shall provide opportunities for recreational activities appropriate to the needs, interests, and ages of the clients being served.

(8) Food Service.

(a) The facility shall have organized dietary services that are directed and staffed by adequate qualified personnel. The facility may contract with an outside food management company, if the company has a dietitian who serves the facility on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the facility for recommendation on dietetic policies affecting client treatment.

(b) The facility shall have an employee who:

1. Serves as director of the food and dietetic service;

2. Is responsible for the daily management of the dietary services and staff training; and

3. Is qualified by experience or training.

(Rule 0940-5-44-.06, continued)

(c) There shall be a qualified dietitian, full time, part-time, or on a consultant basis.

(d) Menus shall meet the needs of the residents.

1. Therapeutic diets shall be prescribed by the practitioner or practitioners responsible for the care of the clients.

2. Nutritional needs shall be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the clients.

3. A current therapeutic diet manual approved by the dietitian shall be readily available to all facility personnel.

4. Menus shall be planned one week in advance.

(e) Clients shall be provided at least three (3) meals per day. The meals shall constitute an acceptable and/or prescribed diet. There shall be no more than fourteen (14) hours between the evening and morning meal. All food served to the clients shall be of good quality and variety, sufficient quantity, attractive and at safe temperatures. Prepared foods shall be kept hot (140°F. or above) or cold (41°F. or less). The food shall be adapted to the habits, preferences and physical abilities of the clients.

(f) Sufficient food provision capabilities and dining space shall be provided.

(g) A forty-eight (48) hour supply of food shall be maintained and properly stored at all times.

(h) Appropriate equipment and utensils for cooking and serving food shall be provided in sufficient quantity to serve all clients and shall be in good repair.

(i) The kitchen shall be maintained in a clean and sanitary condition.

(j) All equipment, utensils and dishes shall be washed and sanitized after each use.

(9) Transportation Services.

(a) If the facility or employees of the facility provide transportation to clients in vehicles owned either by the facility or by the employee, the governing body shall ensure that the following requirements are met:

1. All vehicles shall be maintained and operated in a safe manner;

2. All staff providing transportation shall possess an appropriate driver's license from the Tennessee Department of Safety, and documentation of such license shall be maintained in the facility's records;

3. All facility-owned and staff-owned vehicles used for client transportation shall be adequately covered by vehicular liability insurance for personal injury to occupants of the vehicle, and documentation of such insurance shall be maintained in the facility's records; and,

4. Appropriate safety restraints shall be used as required by state and federal law.

(10) Laundry.

(Rule 0940-5-44-.06, continued)

(a) The facilities shall have a laundry available or shall provide arrangement for laundry of linens.

1. Appropriate storage area for soiled linen and clients' clothing shall be provided.

2. Clean linen shall be maintained in sufficient quantity to provide for the needs of the clients and changed whenever necessary.

(b) Washers and dryers and soiled linen rooms are prohibited in the kitchen or opening into the kitchen or dining area. Soiled laundry shall not be transported through the kitchen or dining areas. The building design and layout shall be altered to insure the separations. Exterior routes to the laundry room unless completely enclosed will not be an acceptable alternative.

(c) In new construction, washers and dryers shall be in separate rooms with appropriate air flow and pressure relationship. In existing facilities air flows and pressure relationships shall be maintained.

(11) Housekeeping.

(a) Each facility shall have routine cleaning of articles and surfaces such as furniture, floors, walls, ceilings, supply, and exhaust grills and lighting fixtures.

(b) Sufficient and proper cleaning supplies and equipment shall be available to housekeeping staff. Cleaning supplies, toxic substances, and equipment shall be secured at all times to prevent access by clients. Toxic substances shall not be left unattended when not secured.

(c) A closet for janitorial supplies shall be provided.

Authority: *T.C.A. §§4-5-202 through 4-5-206, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-222, 68-11-305, and 68-11-308 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Amendment filed April 30, 2003; effective July 14, 2003. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

0940-5-44-.07 BUILDING STANDARDS.

(1) The residential detoxification treatment facility must be constructed, arranged, and maintained to ensure the safety of the resident.

(2) The condition of the physical plant and the overall residential detoxification treatment facility environment must be developed and maintained in such a manner that the safety and well-being of residents are assured.

(3) No new residential detoxification treatment facility shall hereafter be constructed, nor shall major alterations be made to existing residential detoxification treatment facilities, or change in residential detoxification treatment facility type be made without the prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new residential detoxification treatment facility is licensed or before any alteration or expansion of a licensed residential detoxification treatment facility can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor

(Rule 0940-5-44-.07, continued)

alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer.

(4) After the application and licensure fees have been submitted, the building construction plans must be submitted to the department. All new facilities shall conform to the current addition of the Standard Building Code, the National Fire Protection Code (NFPA), the National Electrical Code, and the U.S Public Health Service Food Code as adopted by the Board for Licensing Health Care Facilities. When referring to height, area or construction type, the Standard Building Code shall prevail. All new and existing facilities are subject to the requirements of the Americans with Disabilities Act (A.D.A.). Where there are conflicts between requirements in the above listed codes and regulations and provisions of this chapter, the most restrictive shall apply.

(5) The codes in effect at the time of submittal of plans and specifications, as defined by these regulations shall be the codes to be used throughout the project.

(6) Review of plans and specifications shall be acknowledged in writing with copies sent to the architect and the owner, manager or other executive of the institution. The distribution of such review may be modified at the discretion of the department.

(7) All construction shall be executed in accordance with the approved plans and specifications.

(8) All new construction and renovations to residential detoxification treatment facilities, other than minor alterations not affecting fire and life safety or functional issues, shall be performed in accordance with the specific requirements of these regulations governing new construction in residential detoxification treatment facilities, including the submission of phased construction plans and the final drawings and the specifications to each.

(9) In the event submitted materials do not appear to satisfactorily comply with 0940-5-44-.07 (4) the department shall furnish a letter to the party submitting the plans which shall list the particular items in question and request further explanation and/or confirmation of necessary modifications.

(10) Notice of satisfactory review from the department constitutes compliance with this requirement if construction begins within one hundred eighty (180) days of the date of such notice. This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, regulations, ordinances, codes or rules of any responsible agency.

(11) Final working drawings and specifications shall be accurately dimensioned and include all necessary explanatory notes, schedules and legends. The working drawings and specifications shall be complete and adequate for contract purposes.

(12) Prior to final inspection, a CD Rom disc, in TIF or DMG format, of the final approved plans including all shop drawings, sprinkler, calculations, hood and duct, addenda, specifications, etc., shall be submitted to the department.

(13) Detailed plans shall be drawn to a scale of at least one-eighth inch equals one foot (1/8” = 1’), and shall show the general arrangement of the building, the intended purpose and the fixed equipment in each room, with such additional information as the department may require. These plans shall be prepared by an architect or engineer licensed to practice in the State of Tennessee. The plans shall contain a certificate signed by the architect or engineer that to the best of his or her knowledge or belief the plans conform to all applicable codes.

(Rule 0940-5-44-.07, continued)

(a) Two (2) sets of plans shall be forwarded to the appropriate section of the department for review. After receipt of approval of phased construction plans, the owner may proceed with site grading and foundation work prior to receipt of approval of final plans and specifications with the understanding that such work is at the owner's risk and without assurance that final approval of final plans and specifications shall be granted. Final plans and specifications shall be submitted for review and approval. Final approval must be received before proceeding beyond foundation work.

(b) Review of plans does not eliminate responsibility of owner and/or architect to comply with all rules and regulations.

(14) Specifications shall supplement all drawings. They shall describe the characteristics of all materials, products and devices, unless fully described and indicated on the drawings. Specification copies should be bound in an 8½ x 11 inch folder.

(15) Drawings and specifications shall be prepared for each of the following branches of work: Architectural, Structural, Mechanical, Electrical and Sprinkler.

(16) Architectural drawings shall include:

(a) Plot plan(s) showing property lines, finish grade, location of existing and proposed structures, roadways, walks, utilities and parking areas;

(b) Floor plan(s) showing scale drawings of typical and special rooms, indicating all fixed and movable equipment and major items of furniture;

(c) Separate life safety plans showing the compartment(s), all means of egress and exit markings, exits and travel distances, dimensions of compartments and calculation and tabulation of exit units. All fire and smoke walls must be identified;

(d) The elevation of each facade;

(e) The typical sections throughout the building;

(f) The schedule of finishes;

(g) The schedule of doors and windows;

(h) Roof plans;

(i) Details and dimensions of elevator shaft(s), car platform(s), doors, pit(s), equipment in the machine room, and the rates of car travel must be indicated for elevators; and

(j) Code analysis.

(17) Structural drawings shall include:

(a) Plans of foundations, floors, roofs and intermediate levels which show a complete design with sizes, sections and the relative location of the various members;

(b) Schedules of beams, girders and columns; and

(c) Design live load values for wind, roof, floor, stairs, guard, handrails, and seismic.

(18) Mechanical drawings shall include:

(Rule 0940-5-44-.07, continued)

(a) Specifications which show the complete heating, ventilating, fire protection, medical gas systems and air conditioning systems;

(b) Water supply, sewerage and HVAC piping systems;

(c) Pressure relationships shall be shown on all floor plans;

(d) Heating, ventilating, HVAC piping, medical gas systems and air conditioning systems with all related piping and auxiliaries to provide a satisfactory installation;

(e) Water supply, sewage and drainage with all lines, risers, catch basins, manholes and cleanouts clearly indicated as to location, size, capacities, etc., and location and dimensions of septic tank and disposal field; and,

(f) Color coding to show clearly supply, return and exhaust systems.

(19) Electrical drawings shall include:

(a) A certification that all electrical work and equipment is in compliance with all applicable local codes and laws, and that all materials are currently listed by recognized testing laboratories;

(b) All electrical wiring, outlets, riser diagrams, switches, special electrical connections, electrical service entrance with service switches, service feeders and characteristics of the light and power current, and transformers when located within the building;

(c) The electrical system, which shall comply with applicable codes, and shall include:

1. The fire alarm system; and

2. The emergency power system including automatic services as defined by the codes.

(d) Color coding to show all items on emergency power.

(20) Sprinkler drawings shall include:

(a) Shop drawings, hydraulic calculations, and manufacturer cut sheets;

(b) Site plan showing elevation of fire hydrant to building, test hydrant, and flow data (Data from within a 12 month period); and

(c) Show "Point of Service" where water is used exclusively for fire protection purposes.

(21) No system of water supply, plumbing, sewage, garbage or refuse disposal shall be installed nor shall any existing system be materially altered or extended until complete plans and specifications for the installation, alteration or extension have been submitted to the department and show that all applicable codes have been met and necessary approval has been obtained.

(a) Before the facility is used, the water supply system shall be approved by the Tennessee Department of Environment and Conservation.

(Rule 0940-5-44-.07, continued)

(b) Sewage shall be discharged into a municipal system or approved package system where available; otherwise, the sewage shall be treated and disposed of in a manner of operation approved by the Department of Environment and Conservation and shall comply with existing codes, ordinances and regulations which are enforced by cities, counties or other areas of local political jurisdiction.

(c) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105°F.and 115°F.

(22) The following alarms are required and shall be monitored twenty-four (24) hours per day:

(a) Fire alarms; and

(b) Generators (if applicable)

(23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms.

(24) With the submission of plans the facility shall specify the evacuation capabilities of the residents as defined in the National Fire Protection Code (NFPA). This declaration will determine the design and construction requirements of the facility.

(25) A minimum of eighty (80) square feet of bedroom space must be provided each resident, except those existing facilities licensed prior to this requirement. No bedroom shall have more than four (4) beds. Privacy screens or curtains shall be provided and used when requested by the resident.

(26) Living room and dining areas capable of accommodating all residents shall be provided, with a minimum of fifteen (15) square feet per resident per dining area.

(27) Each toilet, lavatory, bath or shower shall serve no more than eight (8) persons. Grab bars and non-slip surfaces shall be installed at tubs and showers.

Authority: *T.C.A. §§4-5-202 through 4-5-206, 6-11-202, 68-11-204, 6-11-206, and 68-11-209 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Amendment filed February 18, 2003; effective May 4, 2003. Amendment filed April 30, 2003; effective July 14, 2003. Repeal and new rule filed January 4, 2006; effective March 20, 2006. Amendment filed June 21, 2007; effective September 4, 2007. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

0940-5-44-.08 LIFE SAFETY.

(1) Any residential detoxification treatment facility which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.

(2) The residential detoxification treatment facility shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for new residential detoxification treatment facility personnel in each separate building. There shall be

(Rule 0940-5-44-.08, continued)

one fire drill per quarter during sleeping hours. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of client(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information.

(3) Residents who cannot evacuate within thirteen (13) minutes may be retained in the facility so long as such residents are retained in designated areas in accordance with the Standard Building Code and the National Fire Protection Code (NFPA).

(4) Each resident's room shall have a door that opens directly to the outside or a corridor which leads directly to an exit door and must always be capable of being unlocked by the resident.

(5) Doors to residents' rooms shall not be louvered.

(6) Corridors shall be lighted at all times, to a minimum of one foot candle.

(7) General lighting and night lighting shall be provided for each resident. Night lighting shall be equipped with emergency power.

(8) Corridors and exit doors shall be kept clear of equipment, furniture and other obstacles at all times. There shall be a clear passage at all times from the exit doors to a safe area.

(9) Combustible finishes and furnishings shall not be used.

(10) Open flame and portable space heaters shall not be permitted in the facility. Cooking appliances other than microwave ovens shall not be allowed in sleeping rooms.

(11) All heaters shall be guarded and spaced to prevent ignition of combustible material and accidental burns. The guard shall not have a surface temperature greater than 120°F.

(12) Fireplaces and/or fireplace inserts may be used only if provided with guards or screens which are secured in place. Fireplaces and chimneys shall be inspected and cleaned annually and verified documentation shall be maintained.

(13) All electrical equipment shall be maintained in good repair and in safe operating condition.

(14) Electrical cords shall not be run under rugs or carpets.

(15) The electrical systems shall not be overloaded. Power strips must be equipped with circuit breakers. Extension cords shall not be used.

(16) All facilities must have electrically-operated smoke detectors with battery back-up power operating at all times in, at least, sleeping rooms, day rooms, corridors, laundry room, and any other hazardous areas.

(17) Fire extinguishers, complying with NFPA 10, shall be provided and mounted so they are accessible to all residents in the kitchen, laundries and at all exits. Extinguishers in the kitchen and laundries shall be a minimum of 2-A: 10-BC and an extinguisher with a rating of 20-A shall be adjacent to every hazardous area. The minimum travel distance shall not exceed fifty (50) feet between the extinguishers.

(Rule 0940-5-44-.08, continued)

(18) The facility shall have written policies and procedures addressing smoking. The facility must have designated smoking areas that shall be provided with ashtrays. If smoking is only permitted outside the facility, the facility must make accommodations to address inclement weather. Residents who smoke shall be evaluated as to whether they require supervision to prevent the starting of fires or hurting themselves. The evaluation shall be documented. Appropriate supervision shall be provided as required. Smoking in bed is prohibited.

(19) No smoking signs shall be posted in areas where oxygen is used or stored.

(20) Trash and other combustible waste shall not be allowed to accumulate within and around the facility and shall be stored in appropriate containers with tight-fitting lids. Resident rooms shall be furnished with a UL approved trash container.

(21) All safety equipment shall be maintained in good repair and in a safe operating condition.

(22) Janitorial supplies shall be kept locked and inaccessible to residents. If residents are permitted or required to use janitorial supplies, the facility shall have written policies and procedures addressing their use.

(23) Flammable liquids shall be stored in approved containers and stored away from the living areas of the facility.

(24) Floor and dryer vents shall be cleaned as frequently as needed to prevent accumulation of lint, soil and dirt.

(25) Emergency telephone numbers must be posted near a telephone accessible to the residents.

(26) The physical environment shall be maintained in a safe, clean and sanitary manner.

(a) Any condition on the facility site conducive to the harboring or breeding of insects, rodents or other vermin shall be prohibited. Chemical substances of a poisonous nature used to control or eliminate vermin shall be properly identified. Such substances shall not be stored with or near food or medications.

(b) The building shall not become overcrowded with a combination of the facility's residents and other occupants.

(c) Each resident bedroom shall contain a chair, bed, mattress, springs, linens, chest of drawers and wardrobe or closet space, either provided by the facility or by the resident if the resident prefers. All furniture provided by the resident must meet NFPA. All residents' clothing must be maintained in good repair and suitable for the use of the residents.

(d) The building and its heating, cooling, plumbing and electrical systems shall be maintained in good repair and in clean condition at all times.

(e) Temperatures in residents' rooms and common areas shall not be less than 65°F.and no more than 85°F.

Authority: *T.C.A. §§4-5-202 through 4-5-206, 68-11-202, 68-11-204, 68-11-206, and 68-11-209 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Repeal and new rule filed January 4, 2006; effective March 20, 2006. Amendment filed June 21, 2007; effective September 4, 2007. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

(Rule 0940-5-44-.08, continued)

0940-5-44-.09 INFECTIOUS AND HAZARDOUS WASTE.

(1) Each Residential Detoxification Treatment Facilities must develop, maintain and implement written policies and procedures for the definition and handling of its infectious and hazardous waste. These policies and procedures must comply with the standards of this section and all other applicable state and federal regulations.

(2) The following waste shall be considered to be infectious waste:

(a) Waste contaminated by residents who are isolated due to communicable disease, as provided in the U.S. Centers for Disease Control “Guidelines for Isolation Precautions in Hospitals”;

(b) Cultures and stocks of infectious agents including specimen cultures collected from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures;

(c) Waste human blood and blood products such as serum, plasma, and other blood components;

(d) Pathological waste, such as tissues, organs, body parts, and body fluids that are removed during surgery and autopsy;

(e) All discarded sharps (including but not limited to, hypodermic needles, syringes, pasteur pipettes, broken glass, scalpel blades) used in client care or which have come into contact with infectious agents during use in medical, research, or industrial laboratories; and

(f) Other waste determined to be infectious by the facility in its written policy.

(3) Infectious and hazardous waste must be segregated from other waste at the point of generation (i.e., the point at which the material becomes a waste) within the facility.

(4) Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the package will contain, how the waste will be treated and disposed, and how it will be handled and transported, prior to treatment and disposal.

(a) Contaminated sharps must be directly placed in leakproof, rigid, and puncture-resistant containers which must be tightly sealed.

(b) Whether disposable or reusable, all containers, bags, and boxes used for containment and disposal of infectious waste must be conspicuously identified. Packages containing infectious waste which pose additional hazards (including but not limited to, chemical and radiological) must also be conspicuously identified to clearly indicate those additional hazards.

(c) Reusable containers for infectious waste must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.

(Rule 0940-5-44-.09, continued)

(d) Opaque packaging must be used for pathological waste.

(5) After packaging, waste must be handled and transported by methods ensuring containment and preservation of the integrity of the packaging, including the use of secondary containment where necessary. Plastic bags of infectious waste must be transported by hand.

(6) Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons.

(a) Waste must be stored in a manner and location which affords protection from animals, precipitation, wind, and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents, and does not create a nuisance.

(b) Pathological waste must be promptly treated, disposed of, or placed into refrigerated storage.

(7) In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the facility must ensure that proper actions are immediately taken to:

(a) Isolate the area from the public and all non-essential personnel;

(b) To the extent practicable, repackage all spilled waste and contaminated debris in accordance with the requirements of paragraph 6 of this section;

(c) Sanitize all contaminated equipment and surfaces according to written policies and procedures which specify how this will be done appropriately; and

(d) Complete an incident report and maintain a copy on file.

(8) Except as provided otherwise in this rule a facility must treat or dispose of infectious waste by one or more of the methods specified in this paragraph.

(a) A facility may treat infectious waste in an on-site sterilization or disinfection device, or in an incinerator or a steam sterilizer, which has been designed, constructed, operated and maintained so that infectious waste treated in such a device is rendered non-infectious and is, if applicable, authorized for that purpose pursuant to current rules of the Department of Environment and Conservation. A valid permit or other written evidence of having complied with the Tennessee Air Pollution Control Regulations shall be available for review, if required. Each sterilizing or disinfecting cycle must contain appropriate indicators to assure that conditions were met for proper sterilization or disinfection or materials included in the cycle, and appropriate records kept. Proper operation of such devices must be verified at least monthly, and records of the monthly verifications shall be available for review. Waste that contains toxic chemicals that would be violatilized by steam must not be treated in steam sterilizers. Infectious waste that has been rendered to carbonized or mineralized ash shall be deemed non-infectious. Unless otherwise hazardous and subject to the hazardous waste management requirements of the current rules of the Department of Environment and Conservation, such ash shall be disposable as a (non-hazardous) solid waste under current rules of the Department of Environment and Conservation.

(Rule 0940-5-44-.09, continued)

(b) A facility may discharge liquid or semi-liquid infectious waste to the collection sewerage system of a wastewater treatment facility which is subject to a permit pursuant to T.C.A. §§ 69-3-101, et seq., provided that such discharge is in accordance with any applicable terms of that permit and/or any applicable municipal sewer use requirements.

(c) Any health care facility accepting waste from another state must promptly notify the Department of Environment and Conservation, county, and city public health agencies, and must strictly comply with all applicable local, state and federal regulations.

(9) The facility may have waste transported off-site for storage, treatment, or disposal. Such arrangements must be detailed in a written contract, available for review. If such off-site location is located within Tennessee, the facility must ensure that it has all necessary State and local approvals, and such approvals shall be available for review. If the off-site location is within another state, the facility must notify in writing all public health agencies with jurisdiction that the location is being used for management of the facility's waste. Waste shipped off-site must be packaged in accordance with applicable federal and state requirements. Waste transported to a sanitary landfill in this state must meet the requirements of current rules of the Department of Environment and Conservation.

(10) Human anatomical remains which are transferred to a mortician for cremation or burial shall be exempt from the requirements of this rule.

(11) All garbage, trash and other non-infectious waste shall be stored and disposed of in a manner that must not permit the transmission of disease, create a nuisance, provide a breeding place for insects and rodents, or constitute a safety hazard. All containers for waste shall be water tight, constructed of easily-cleanable material, and shall be kept on elevated platforms.

Authority: *T.C.A. §§4-5-202 through 4-5-206, 68-11-202, 68-11-204, 68-11-206, and 68-11-209 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

0940-5-44-.10 RECORDS AND REPORTS.

(1) A yearly statistical report, the "Joint Annual Report of Residential Detoxification Treatment Facilities", shall be submitted to the department. The forms are mailed to each Residential Detoxification Treatment Facility by the department each year. The forms shall be completed and returned to the department within sixty (60) days following receipt of the form.

(2) Client Records.

(a) The governing body shall ensure that an individual client record is maintained for each client being served which minimally includes the following information:

1. The name of the client;

2. The address of the client;

3. The telephone number of the client;

4. The sex of the client;

5. The date of the client's birth;

(Rule 0940-5-44-.10, continued)

6. The date of the client's admission to the facility;

7. The source of the client's referral to the facility;

8. The name, address, and telephone number of an emergency contact person;

9. If the facility charges fees for its services, a written fee agreement dated and signed by the client (or the client's legal representative) prior to provision of any services other than emergency services. This agreement shall include at least the following information:

   (i) The fee or fees to be paid by the client;

   (ii) The services covered by such fees; and

   (iii) Any additional charges for services not covered by the basic service fee.

10. Appropriate signed and dated informed consent and authorization forms for the release or obtainment of information about the client;

11. Documentation that the client or someone acting on behalf of the client has been informed of the client's rights and responsibilities and of the facility's general rules affecting the client;

12. Documentation of all drugs prescribed or administered to the client by the facility which indicates date prescribed, type, dosage, frequency, amount and reason;

13. A list of each individual article of personal property brought to the facility by the client valued at fifty dollars ($50.00) or more including its disposition, if no longer in use;

14. Written accounts of all monies received and disbursed on behalf of the client;

15. Reports of the client's medical problems, accidents, seizures and illnesses, and treatments for such accidents, seizures and illnesses;

16. Reports of the client's significant behavior incidents;

17. Reports of any instance of restraint or restriction of the client with documented justification and authorization;

18. Progress notes which shall be entered in chronological order in the client's record and includes written documentation of progress or lack thereof within the treatment plan for each treatment contact or on a weekly basis;

19. A discharge summary, within thirty (30) days of release, discharge, or transfer which shall minimally include but not be limited to the following:

   (i) Date of discharge;

   (ii) Reasons for discharge;

   (iii) Presenting problem at intake;

(Rule 0940-5-44-.10, continued)

(iv) Initial condition and condition of the client at discharge;

(v) Medication summary if applicable;

(vi) Treatment services provided and treatment/outcome results;

(vii) The final assessment or psychiatric and physical diagnosis;

(viii) Written recommendations and specific referrals for implementing aftercare services, including medications, the type of contact, planned frequency of contact, and responsible staff. Aftercare plans shall be developed with the knowledge and cooperation of the client; the client's response to the aftercare plan shall be noted in the discharge summary, or a note shall be made that the client was not available and why. In the event of death of a client, a summary statement including this information shall be documented in the record; and,

(ix) The signature of the staff member completing the summary;

(b) Records shall be retained for a minimum of ten (10) years even if the facility discontinues operations; and

(c) Upon the closing of any facility, a person of authority representing the facility may request final storage or disposition of the facility's records by the Tennessee Department of Health.

(3) The Residential Detoxification Treatment Facility shall retain legible copies of the following records and reports in the facility for the next thirty-six (36) months following their issuance:

(a) Local fire safety inspections, if any;

(b) Local building code inspections, if any;

(c) Fire marshal reports, if any;

(d) Department licensure and fire safety inspections and surveys;

(e) Maintenance records of all safety equipment and vehicles used in client transportation; and

(f) Any other inspections conducted by the Department, federal, state or local agencies.

(4) Copies of the records and reports listed above, except for client records as set forth in section (2) shall be maintained in a location convenient to the public and, shall be available during normal business hours. They shall be made available for inspection by any person who requests to view them. Each client and/or person assuming any financial responsibility for a client shall be fully informed, before or at the time of admission, of the availability of these reports.

(5) All applications, certificates, records, reports and all legal documents, petitions and records made or information received pursuant to treatment in a Residential Detoxification Treatment Facility directly or indirectly identifying a client or former client shall be kept confidential and shall not be disclosed by any person except insofar:

(Rule 0940-5-44-.10, continued)

(a) As a court may direct upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make such disclosure would be contrary to public interest or to the detriment of either party to the proceedings, consistent with the provisions of 42 CFR Part 2.

(b) Nothing in this subparagraph shall prohibit disclosure, upon proper inquiry, of information as to the current medical condition of a resident to any members of the family of a resident or to his relatives or friends providing that conditions of 42 CFR Part 2 have been met.

(6) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient.

(a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:

1. medication errors;

2. aspiration in a non-intubated patient related to conscious/moderate sedation;

3. intravascular catheter related events including necrosis or infection requiring repair or intravascular catheter related pneumothorax;

4. volume overload leading to pulmonary edema;

5. blood transfusion reactions, use of wrong type of blood and/or delivery of blood to the wrong patient;

6. perioperative/periprocedural related complication(s) that occur within 48 hours of the operation or the procedure, including a procedure which results in any new central neurological deficit or any new peripheral neurological deficit with motor weakness;

7. burns of a second or third degree;

8. falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma, but does not include fractures resulting from pathological conditions;

9. procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include:

(i) procedure related injury requiring repair or removal of an organ;

(ii) hemorrhage;

(iii) displacement, migration or breakage of an implant, device, graft or drain;

(iv) post operative wound infection following clean or clean/contaminated case;

(Rule 0940-5-44-.10, continued)

(v) any unexpected operation or reoperation related to the primary procedure;

(vi) hysterectomy in a pregnant woman;

(vii) ruptured uterus;

(viii) circumcision;

(ix) incorrect procedure or incorrect treatment that is invasive;

(x) wrong patient/wrong site surgical procedure;

(xi) unintentionally retained foreign body;

(xii) loss of limb or organ, or impairment of limb if the impairment is present at discharge or for at least two (2) weeks after occurrence;

(xiii) criminal acts;

(xiv) suicide or attempted suicide;

(xv) elopement from the facility;

(xvi) infant abduction, or infant discharged to the wrong family;

(xvii) adult abduction;

(xviii) rape;

(xix) patient altercation;

(xx) patient abuse, patient neglect, or misappropriation of resident/patient funds;

(xxi) restraint related incidents; or

(xxii) poisoning occurring within the facility.

(b) Specific incidents that might result in a disruption of the delivery of health care services at the facility shall also be reported to the department, on the unusual event form, within seven (7) days after the facility learns of the incident. These specific incidents include the following:

1. strike by the staff at the facility;

2. external disaster impacting the facility;

3. disruption of any service vital to the continued safe operation of the facility or to the health and safety of its patients and personnel; and

4. fires at the facility which disrupt the provision of patient care services or cause harm to patients or staff, or which are reported by the facility to any entity, including but not limited to a fire department, charged with preventing fires.

(Rule 0940-5-44-.10, continued)

(c) For health services provided in a "home" setting, only those unusual events actually witnessed or known by the person delivering health care services are required to be reported.

(d) Within forty (40) days of the identification of the event, the facility shall file with the department a corrective action report for the unusual event reported to the department. The department's approval of a Corrective Action Report will take into consideration whether the facility utilized an analysis in identifying the most basic or causal factor(s) that underlie variation in performance leading to the unusual event by (a) determining the proximate cause of the unusual event, (b) analyzing the systems and processes involved in the unusual event, (c) identifying possible common causes, (d) identifying potential improvements, and (e) identifying measures of effectiveness. The corrective action report shall either: (1) explain why a corrective action report is not necessary; or (2) detail the actions taken to correct any error identified that contributed to the unusual event or incident, the date the corrections were implemented, how the facility will prevent the error from recurring in the future and who will monitor the implementation of the corrective action plan.

(e) The department shall approve in writing, the corrective action report if the department is satisfied that the corrective action plan appropriately addresses errors that contributed to the unusual event and takes the necessary steps to prevent the recurrence of the errors. If the department fails to approve the corrective action report, then the department shall provide the facility with a list of actions that the department believes are necessary to address the errors. The facility shall be offered an informal meeting with the Commissioner or the Commissioner's representative to attempt to resolve any disagreement over the corrective action report. If the department and the facility fail to agree on an appropriate corrective action plan, then the final determination on the adequacy of the corrective action report shall be made by the Board after a contested case hearing.

(f) The event report reviewed or obtained by the department shall be confidential and not subject to discovery, subpoena or legal compulsion for release to any person or entity, nor shall the report be admissible in any civil or administrative proceeding other than a disciplinary proceeding by the department or the appropriate regulatory board. The report is not discoverable or admissible in any civil or administrative action except that information in any such report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions against the impacted facility. The department must reveal upon request its awareness that a specific event or incident has been reported.

(g) The department shall have access to facility records as allowed in Title 68, Chapter 11, Part 3. The department may copy any portion of a facility medical record relating to the reported event unless otherwise prohibited by rule or statute. This section does not change or affect the privilege and confidentiality provided by T.C.A. §63-6-219.

(h) The department, in developing the unusual event report form, shall establish an event occurrence code that categorizes events or specific incidents by the examples set forth above in (a) and (b). If an event or specific incident fails to come within these examples, it shall be classified as "other" with the facility explaining the facts related to the event or incident.

(i) This does not preclude the department from using information obtained under these rules in a disciplinary action commenced against a facility, or from taking a disciplinary action against a facility. Nor does this preclude the department from sharing such information with any appropriate governmental agency charged by federal or state law

(Rule 0940-5-44-.10, continued)

with regulatory oversight of the facility. However, all such information must at all times be maintained as confidential and not available to the public. Failure to report an unusual event, submit a corrective action report, or comply with a plan of correction as required herein may be grounds for disciplinary action pursuant to T.C.A. §68-11-207.

(j) The affected patient and/or the patient's family, as may be appropriate, shall also be notified of the event or incident by the facility.

(k) During the second quarter of each year, the Department shall provide the Board an aggregate report summarizing by type the number of unusual events and incidents reported by facilities to the Department for the preceding calendar year.

(l) The Department shall work with representatives of facilities subject to these rules, and other interested parties, to develop recommendations to improve the collection and assimilation of specific aggregate health care data that, if known, would track health care trends over time and identify system-wide problems for broader quality improvement. The goal of such recommendations should be to better coordinate the collection of such data, to analyze the data, to identify potential problems and to work with facilities to develop best practices to remedy identified problems. The Department shall prepare and issue a report regarding such recommendations.

Authority: *T.C.A. §§4-5-202 through 4-5-206, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 63-11-213 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

0940-5-44-.11 CLIENT RIGHTS.

(1) Clients in any approved Residential Detoxification Treatment Facility shall be granted opportunities for visitation and communication with their families consistent with an effective treatment program. Clients shall be permitted to consult with counsel at any time. Neither mail nor other communication to or from a client may be intercepted, read or censored except as set forth in (a)(iii) below. The facility may adopt reasonable policies regarding the use of the telephone in the facility. Clients shall not be abused or neglected or administered corporal punishment.

The following rights of clients shall apply whenever appropriate:

(a) Visitors and/or Mail. Every client shall be entitled to:

1. Receive visitors during regular visiting hours. The treating physician or facility director has the right to make reasonable policies regarding visitors and visiting hours and the use of telephone and telegraph facilities.

2. Communicate by sealed mail or otherwise with the client's attorney, physician, minister, guardian, family and the courts; and,

3. Receive uncensored mail from the client's attorney or personal physician. All other incoming mail or communications may be read before being delivered to the client if the treating physician believes such action is necessary for the medical welfare of the client who is the intended recipient. However, any mail or other communication which is not delivered to the client for whom it is intended shall be returned immediately to the sender.

(Rule 0940-5-44-.11, continued)

(b) Civil Rights. No client admitted to a facility shall, solely by reason of such admission, be denied the right to dispose of property, execute instruments, make purchases, enter into contractual relationships, give informed consent to treatment and vote, unless such client has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.

(c) Informing Clients of Rights: Acknowledgment. Qualified alcohol and drug abuse personnel of the facility or treatment resource shall orally inform a client, who is admitted for diagnosis, observation and treatment, in simple, non-technical language of all rights accorded to clients by these rules. Each such statement shall also be provided to the client in writing at the time of admittance. The client shall sign on the line provided for his signature, acknowledging that he has been verbally informed of his rights. The client's signature shall be acknowledged by at least one (1) disinterested witness. Such witness shall sign in the presence of qualified alcohol and other drug abuse personnel or supervisor and the client.

(d) Each client has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services. This right of self-determination may be effectuated by an advance directive.

Authority: *T.C.A. §§4-5-202 through 4-5-206, 68-11-202, 68-11-209, 68-11-302, and 68-11-304 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

0940-5-44-.12 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING.

(1) Pursuant to this Rule, each residential detoxification treatment facility shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a client who is incompetent or who lacks capacity, including but not limited to allowing the withholding of CPR measures from individual clients. An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(2) An adult or emancipated minor may execute an advance directive for health care. The advance directive may authorize an agent to make any health care decision the client could have made while having capacity, or may limit the power of the agent, and may include individual instructions. The effect of an advance directive that makes no limitation on the agent's authority shall be to authorize the agent to make any health care decision the client could have made while having capacity.

(3) The advance directive shall be in writing, signed by the client, and shall either be notarized or witnessed by two (2) witnesses. Both witnesses shall be competent adults, and neither of them may be the agent. At least one (1) of the witnesses shall be a person who is not related to the client by blood, marriage, or adoption and would not be entitled to any portion of the estate of the client upon the death of the client. The advance directive shall contain a clause that attests that the witnesses comply with the requirements of this paragraph.

(4) Unless otherwise specified in an advance directive, the authority of an agent becomes effective only upon a determination that the client lacks capacity, and ceases to be effective upon a determination that the client has recovered capacity.

(Rule 0940-5-44-.12, continued)

(5) A facility shall use the mandatory advance directive form that meets the requirements of the Tennessee Health Care Decisions Act and has been developed and issued by the Board for Licensing Health Care Facilities.

(6) A determination that a client lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent shall be made by the designated physician, who is authorized to consult with such other persons as he or she may deem appropriate.

(7) An agent shall make a health care decision in accordance with the client's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the client's best interest. In determining the client's best interest, the agent shall consider the client's personal values to the extent known.

(8) An advance directive may include the individual's nomination of a court-appointed guardian.

(9) A health care facility shall honor an advance directive that is executed outside of this state by a nonresident of this state at the time of execution if that advance directive is in compliance with the laws of Tennessee or the state of the client's residence.

(10) No health care provider or institution shall require the execution or revocation of an advance directive as a condition for being insured for, or receiving, health care.

(11) Any living will, durable power of attorney for health care, or other instrument signed by the individual, complying with the terms of Tennessee Code Annotated, Title 32, Chapter 11, and a durable power of attorney for health care complying with the terms of Tennessee Code Annotated, Title 34, Chapter 6, Part 2, shall be given effect and interpreted in accord with those respective acts. Any advance directive that does not evidence an intent to be given effect under those acts but that complies with these regulations may be treated as an advance directive under these regulations.

(12) A client having capacity may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.

(13) A client having capacity may revoke all or part of an advance directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

(14) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or in an advance directive.

(15) An advance directive that conflicts with an earlier advance directive revokes the earlier directive to the extent of the conflict.

(16) Surrogates.

(a) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health care provider. The designation may be oral or written.

(b) A surrogate may make a health care decision for a client who is an adult or emancipated minor if and only if:

(Rule 0940-5-44-.12, continued)

1. the client has been determined by the designated physician to lack capacity, and

2. no agent or guardian has been appointed, or

3. the agent or guardian is not reasonably available.

(c) In the case of a client who lacks capacity, the client's surrogate shall be identified by the supervising health care provider and documented in the current clinical record of the facility at which the client is receiving health care.

(d) The client's surrogate shall be an adult who has exhibited special care and concern for the client, who is familiar with the client's personal values, who is reasonably available, and who is willing to serve.

(e) Consideration may be, but need not be, given in order of descending preference for service as a surrogate to:

1. the client's spouse, unless legally separated;

2. the client's adult child;

3. the client's parent;

4. the client's adult sibling;

5. any other adult relative of the client; or

6. any other adult who satisfies the requirements of 0940-5-44-.12(16)(d).

(f) No person who is the subject of a protective order or other court order that directs that person to avoid contact with the client shall be eligible to serve as the client's surrogate.

(g) The following criteria shall be considered in the determination of the person best qualified to serve as the surrogate:

1. Whether the proposed surrogate reasonably appears to be better able to make decisions either in accordance with the known wishes of the client or in accordance with the client's best interests;

2. The proposed surrogate's regular contact with the client prior to and during the incapacitating illness;

3. The proposed surrogate's demonstrated care and concern;

4. The proposed surrogate's availability to visit the client during his or her illness; and

5. The proposed surrogate's availability to engage in face-to-face contact with health care providers for the purpose of fully participating in the decision-making process.

(h) If the client lacks capacity and none of the individuals eligible to act as a surrogate under 0940-5-44-.12(16)(c) thru 0940-5-44-.12(16)(g) is reasonably available, the

(Rule 0940-5-44-.12, continued)

designated physician may make health care decisions for the client after the designated physician either:

1. Consults with and obtains the recommendations of a facility's ethics mechanism or standing committee in the facility that evaluates health care issues; or

2. Obtains concurrence from a second physician who is not directly involved in the client's health care, does not serve in a capacity of decision-making, influence, or responsibility over the designated physician, and is not under the designated physician's decision-making, influence, or responsibility.

(i) In the event of a challenge, there shall be a rebuttable presumption that the selection of the surrogate was valid. Any person who challenges the selection shall have the burden of proving the invalidity of that selection.

(j) A surrogate shall make a health care decision in accordance with the client's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the client's best interest. In determining the client's best interest, the surrogate shall consider the client's personal values to the extent known to the surrogate.

(k) A surrogate who has not been designated by the client may make all health care decisions for the client that the client could make on the client's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a client upon a decision of the surrogate only when the designated physician and a second independent physician certify in the client's current clinical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the client is highly unlikely to regain capacity to make medical decisions.

(l) Except as provided in 0940-5-44-.12(16)(m):

1. Neither the treating health care provider nor an employee of the treating health care provider, nor an operator of a health care institution nor an employee of an operator of a health care institution may be designated as a surrogate; and

2. A health care provider or employee of a health care provider may not act as a surrogate if the health care provider becomes the client's treating health care provider.

(m) An employee of the treating health care provider or an employee of an operator of a health care institution may be designated as a surrogate if:

1. the employee so designated is a relative of the client by blood, marriage, or adoption; and

2. the other requirements of this section are satisfied.

(n) A health care provider may require an individual claiming the right to act as surrogate for a client to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(17) Guardian.

(a) A guardian shall comply with the client's individual instructions and may not revoke the client's advance directive absent a court order to the contrary.

(Rule 0940-5-44-.12, continued)

(b) Absent a court order to the contrary, a health care decision of an agent takes precedence over that of a guardian.

(c) A health care provider may require an individual claiming the right to act as guardian for a client to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(18) A designated physician who makes or is informed of a determination that a client lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, guardian, or surrogate, shall promptly record the determination in the client's current clinical record and communicate the determination to the client, if possible, and to any person then authorized to make health care decisions for the client.

(19) Except as provided in 0940-5-44-.12(20) thru 0940-5-44-.12(22), a health care provider or institution providing care to a client shall:

(a) comply with an individual instruction of the client and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the client; and

(b) comply with a health care decision for the client made by a person then authorized to make health care decisions for the client to the same extent as if the decision had been made by the client while having capacity.

(20) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience.

(21) A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is:

(a) contrary to a policy of the institution which is based on reasons of conscience, and

(b) the policy was timely communicated to the client or to a person then authorized to make health care decisions for the client.

(22) A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically inappropriate health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.

(23) A health care provider or institution that declines to comply with an individual instruction or health care decision pursuant to 0940-5-44-.12(20) thru 0940-5-44-.12(22) shall:

(a) promptly so inform the client, if possible, and any person then authorized to make health care decisions for the client;

(b) provide continuing care to the client until a transfer can be effected or until the determination has been made that transfer cannot be effected;

(c) unless the client or person then authorized to make health care decisions for the client refuses assistance, immediately make all reasonable efforts to assist in the transfer of the client to another health care provider or institution that is willing to comply with the instruction or decision; and

(Rule 0940-5-44-.12, continued)

(d) if a transfer cannot be effected, the health care provider or institution shall not be compelled to comply.

(24) Unless otherwise specified in an advance directive, a person then authorized to make health care decisions for a client has the same rights as the client to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.

(25) A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(a) complying with a health care decision of a person apparently having authority to make a health care decision for a client, including a decision to withhold or withdraw health care;

(b) declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or

(c) complying with an advance directive and assuming that the directive was valid when made and had not been revoked or terminated.

(26) An individual acting as an agent or surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for health care decisions made in good faith.

(27) A person identifying a surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for such identification made in good faith.

(28) A copy of a written advance directive, revocation of an advance directive, or designation or disqualification of a surrogate has the same effect as the original.

(29) The withholding or withdrawal of medical care from a client in accordance with the provisions of the Tennessee Health Care Decisions Act shall not, for any purpose, constitute a suicide, euthanasia, homicide, mercy killing, or assisted suicide.

(30) Universal Do Not Resuscitate Order (DNR).

(a) The Physicians Order for Scope of Treatment (POST) form, a mandatory form meeting the provisions of the Health Care Decision Act and approved by the Board for Licensing Health Care Facilities, shall be used as the Universal Do Not Resuscitate Order by all facilities. A universal do not resuscitate order (DNR) may be used by a physician for his/her patient with whom he/she has a physician/patient relationship, but only:

1. with the consent of the patient; or

2. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act; or

3. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act is not reasonably available, the physician determines that the

(Rule 0940-5-44-.12, continued)

provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(b) If the client is an adult who is capable of making an informed decision, the client's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke a universal do not resuscitate order. If the client is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the client be resuscitated by the person authorized to consent on the client's behalf shall revoke a universal do not resuscitate order.

(c) Universal do not resuscitate orders shall remain valid and in effect until revoked. Qualified emergency medical services personnel, and licensed health care practitioners in any facility, program or organization operated or licensed by the board for licensing health care facilities or by the department of mental health and developmental disabilities or operated, licensed, or owned by another state agency are authorized to follow universal do not resuscitate orders.

(d) Nothing in these rules shall authorize the withholding of other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or to alleviate pain.

(e) If a person with a universal do not resuscitate order is transferred from one health care facility to another health care facility, the health care facility initiating the transfer shall communicate the existence of the universal do not resuscitate order to the receiving facility prior to the transfer. The transferring facility shall assure that a copy of the universal do not resuscitate order accompanies the client in transport to the receiving health care facility. Upon admission, the receiving facility shall make the universal do not resuscitate order a part of the client's record.

(f) This section shall not prevent, prohibit, or limit a physician from issuing a written order, other than a universal do not resuscitate order, not to resuscitate a client in the event of cardiac or respiratory arrest in accordance with accepted medical practices.

(g) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to the then-current law, shall remain valid and shall be given effect as provided.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-224, 68-11-1801 through 68-11-1815 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Amendment filed April 28, 2003; effective July 12, 2003. Repeal and new rule filed January 4, 2006; effective March 20, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

0940-5-44-.13 DISASTER PREPAREDNESS.

(1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans, for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans shall be readily available at all times in the telephone operator's position or at the security center. Each of the following plans shall be exercised annually prior to the month listed in each plan:

(Rule 0940-5-44-.13, continued)

(a) Fire Safety Procedures Plan (to be exercised at any time during the year) shall include:

1. Minor fires;

2. Major fires;

3. Fighting the fire;

4. Evacuation procedures; and,

5. Staff functions by department and job assignment.

(b) Tornado/Severe Weather Procedures Plan shall include:

1. Staff duties by department and job assignment; and,

2. Evacuation procedures.

(c) Bomb Threat Procedures Plan (to be exercised at any time during the year) shall include:

1. Staff duties;

2. Search team, searching the premises;

3. Notification of authorities;

4. Location of suspicious objects; and,

5. Evacuation procedures.

(d) Floods Procedures Plan, if applicable shall include:

1. Staff duties;

2. Evacuation procedures; and

3. Safety procedures following the flood.

(e) Severe Cold Weather and Severe Hot Weather Procedures Plans shall include:

1. Staff duties;

2. Equipment failures;

3. Insufficient HVAC on emergency power;

4. Evacuation procedures; and

5. Emergency food service.

(f) Earthquake Disaster Procedures Plan shall include:

1. Staff duties;

(Rule 0940-5-44-.13, continued)

2. Evacuation procedures;

3. Safety procedures; and,

4. Emergency services.

(2) All facilities shall participate in the Tennessee Emergency Management local/county emergency plan on an annual basis. Participation includes but is not limited to filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation shall be maintained and shall be made available to survey staff as proof of participation.

Authority: *T.C.A. §§4-5-202 through 4-5-206, 68-11-202, 68-11-204, 68-11-206, and 68-11-209 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed April 27, 2000; effective July 11, 2000. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*

0940-5-44-.14 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST) This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.	Patient's Last Name First Name/Middle Initial Date of Birth

Section A Check One Box Only	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing. ☐ Resuscitate (CPR) ☐ Do Not Attempt Resuscitate (DNR/no CPR) When not in cardiopulmonary arrest, follow orders in B, C, and D.
Section B Check One Box Only	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing. ☐ Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. ☐ Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care. ☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care. Other

(Rule 0940-5-44-.14, continued)

	Instructions:_____
Section C Check One Box Only	ANTIBIOTICS – Treatment for new medical conditions: ☐ No Antibiotics ☐ Antibiotics Other Instructions:_____
Section D Check One Box Only in Each Column	MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible. ☐ No IV fluids (provide other measures to assure comfort) ☐ No feeding tube ☐ IV fluids for a defined trial period ☐ Feeding tube for a defined trial period ☐ IV fluids long-term if indicated ☐ Feeding tube long-term Other Instructions:_____

Section E Must be Completed	Discussed with: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other:_____(Specify)	The Basis for These Orders Is: (Must be completed) ☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown) ☐ Medical indications ☐ (Other)_____ —	
	Physician Name (Print)	Physician Phone Number	Office Use Only
	Physician Signature (Mandatory)	Date	

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences.

(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature	Name (print)	Relationship (write "self" if patient)

Contact Information

Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

(Rule 0940-5-44-.14, continued)

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name:_____ Phone #: _____ Relation: _____

Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name:_____ Phone #: _____ Relation: _____

Address: _____

(Rule 0940-5-44-.14, continued)

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):

☐ Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

☐ Permanent Confusion: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

☐ Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.

☐ End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.

☐ Yes ☐ No	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	Life Support/Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ Yes ☐ No	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.:_____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

(Rule 0940-5-44-.14, continued)

Signature: _____

DATE:_____

(Patient)

Witnesses:

1, I am a competent adult who is not named as the agent.

_____

I witnessed the patient's signature on this form. Signature of witness number 1

2. I am a competent adult who is not named as the agent.

_____

I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF_____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____

Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005
Acknowledgement to Project GRACE for inspiring the development of this form.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805 and Executive Order 44 (February 23, 2007).* ***Administrative History:*** *Original rule filed February 16, 2007; effective May 2, 2007. Per Executive Order 44 (February 23, 2007), rule was transferred from 1200-8-23 on May 15, 2008.*